STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152025	A. BUILDING 00 B. WING	06/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRA SPECIALTY HOSPITAL	2401 W UNIVERSITY AVE 8TH FL NOR MUNCIE, IN47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	The visit was for a licensure survey. Facility Number: 004811 Survey Date: 06-01-11 to 06-03-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor QA: claughlin 07/25/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0306	410 IAC 15-1.4-1(c)(6)(A) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (A) Ensuring the employment of personnel, in accordance with state and federal rules, whose qualifications are commensurate with anticipated job responsibilities. Based on policy and procedure review, personnel file review, and interview, the facility failed to ensure the implementation of its policy related to criminal background checks for 3 of 15 employee files reviewed. (P8, P11 and P13) Findings: 1. at 3:45 PM on 6/2/11, review of the policy titled "Abuse, Neglect, and Misappropriation of Patient's Property" ("HFAP Reference # 15.00.00"), indicated on page 3., under "Policy:" "...3. Integra Specialty Hospital will do a criminal background check on all staff according to the specific implementation guidelines for the state of Indiana..." 2. beginning at 10:30 AM on 6/2/11, review of personnel files indicated:	S0306	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed, include stfeps tfaken and tfhe datfe oft correctfon. a. All currentf employees have a criminal histfory background check completfed by Augustf12, 2011. All currentf contfractf/agency stfaftng personnel have a criminal histfory background check completfed by Augustf12, 2011. 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The Human Resource Coordinatfor or designee will requestf and receive ftor all persons who will be working or voluntfeering witfhin tfhe hospitfal a limitfed criminal histfory prior tfo, butf notf latfer tfhan tfhe ftrstf day oft actfual employmentf or exposure tfo patfentfs 3. Who is going tfo be responsible ftor numbers1 & 2 above?	08/31/2011

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	a. agency staff member P8 first worked on 11/6/10 and was lacking documentation of a criminal background check b. employee P11 first began work on 11/16/10 and was lacking documentation of a criminal background check c. employee P13 was hired 7/17/06 and was lacking documentation of a criminal background check 3. interview with staff member NE at 2:30 PM on 6/2/11 indicated there was no written policy and procedure related to criminal history/background checks for new employees 4. interview with staff member NE at 3:45 PM on 6/2/11 indicated: a. a policy (see 1. above) was found related to criminal background checks b. it is unknown why 3 staff members (see 2. above) were lacking criminal background check documentation		a. The Human Resource Coordinatfor will requestf and receive a criminal histfory. The departfmentf supervisor ftor tfhe person working or voluntfeering will verifty tfhe criminal histfory prior tfobutf notf latfer tfhan tfhe ftrstf day oft actfual employmentf or exposure tfo patfentfs	

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S0308	15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.			
	Based on personnel file review and staff interview, the facility failed to ensure the orientation for 9 of 9 agency staff (P1 through P9), and 3 of 6 employed staff, (P10, P11 and P15). Findings: 1. beginning at 10:30 AM on 6/2/11, review of personnel files indicated: a. 3 agency RNs (registered nurses) who worked in 2010 and 2011 were lacking documentation of orientation to the facility b. 3 agency LPNs (licensed practical nurses) who worked in 2010 were lacking documentation of orientation to the facility c. 3 agency PCTs (patient care technicians) who worked in 2010 and 2011 were lacking documentation of orientation to the facility	S0308	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed, include stfeps tfaken and tfhe datfe oft correctfon. a. All persons currentfly working or voluntfeering will havea "Completfon oft Orientfatfon" ftorm completfed by Augustf12, 2011. 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. A new employee orientfatfon and contfractfed agency stfaft orientfatfon policy has been developed and implementfed by Augustf12, 2011. 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. The Human Resource Coordinatfor or designee will ensure tfhatf all persons working or voluntfeering witfh tfhe hospitfal completfes tfhe orientfatfon. The departfmentf supervisor ftor each	08/31/2011

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	d. 2 PCTs hired in November 2010 were lacking documentation of orientation to the facility e. 1 RN hired in November 2010 was lacking documentation of orientation to the facility 2. at 11:35 AM on 6/2/11, interview with staff member NE indicated: a. there is no orientation documentation for agency personnel b. the orientation for staff members P10, P11 and P15 cannot be found 3. interview with staff member NB at 2:40 PM on 6/3/11 indicated: a. the facility has not yet developed orientation requirements for agency staff b. a committee has been/will be "working on this"		person will verifty tfhe completfon oft tfhe orientfatfon	

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S0312	410 IAC 15-1.4-1(c)(6)(D) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on personnel file review and staff interview, the facility failed to ensure that evaluations were performed for 7 of 9 agency staff (P1, P4, P5, P6, P7, P8 and P9) and 1 of 6 employed staff (P15). Findings: 1. beginning at 10:30 AM on 6/2/11, review of personnel files, of those staff who have worked long enough to qualify for an evaluation, indicated: a. agency RN (registered nurse) P1 first worked September 2010 and was lacking a 90 day evaluation b. agency LPN (licensed practical nurse) P4 first worked 10/25/10 and was lacking a 90 day evaluation c. agency LPN P5 first worked 3/29/10 and was lacking a 90 day evaluation and an annual evaluation	S0312	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. The Human Resource Coordinator has audited all current employees to ensure all employees have a current evaluation. A performance evaluation will be completed for all employees by August 31, 2011. The hospital has developed a new contracted/agency staff evaluation policy. All contracted/agency staff will receive an evaluation at the end of the worked shift by their direct supervisor. Any identified performance deficits will be discussed with the person and the employer agency. 2. How are you going to prevent the deficiency from	08/31/2011

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	d. agency LPN P6 first worked 9/14/10 and was lacking a 90 day e. agency PCTs (patient care technicians) P7 and P8 began work on 11/6/10 and were lacking 90 day evaluations f. agency PCT P9 began work 9/29/10 and was lacking a 90 day evaluation g. RN P15 began working 11/23/10 and was lacking a 90 day evaluation 2. interview with staff member NE at 3:45 PM on 6/2/11 indicated there is no facility policy/procedure related to evaluations, but the practice is that they are performed at 90 days and annually after work begins		recurring in the future? a. The Human Resource Coordinator or designee will audit evaluations monthly to ensure compliance. 3. Who is going to be responsible for numbers 1 & 2 above? a. The Human Resource Coordinator or designee will audit evaluations monthly to ensure compliance. All concerns will be forwarded to the Quality Assurance Committee.	

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S0320	410 IAC 15-1.4-1(c)(6)(G) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.			
	Based on policy and procedure review, personnel file review, and staff interview, the facility failed to ensure that post offer physicals/health status reporting was obtained for 4 of 9 agency staff (P1, P2, P3, and P5), and 3 of 6 employed staff (P10, P11 and P15). Findings: 1. at 3:00 PM on 6/2/11, review of the "TLC Management Policy & Procedure Manual" document titled "TB Tests for New Hires" (HR Policy 202), indicated: a. under "Policy:", it reads: "...(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test..." 2. beginning at 10:30 AM on 6/2/11, review of personnel files indicated: a. agency staff members P1, P2, P3, and	S0320	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. The Human Resource Coordinatfor has auditfed all persons employed or voluntfeering witfh tfhe hospitfal tfo ensure all healtfh screens witfh TB tfestf have been perftormed 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The Human Resource Coordinatfor or designee will ensure tfhatf all persons working or voluntfeering witfh tfhe hospitfal completfes tfhe required healtfh screen witfh TB tfestf The departfmentf supervisor ftor each person will verifty tfhe completfon oft tfhe healtfh screen TB tfestf 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All concerns will be ftorwarded tfo tfhe Qualitfy Assurance Commitfee	08/31/2011

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	P5 were lacking post offer physicals/health screening forms in their personnel files b. employee staff P10, P11 and P15 were lacking post offer physical/health screen forms in their files 3. at 2:30 PM on 6/2/11, interview with staff member NE indicated: a. P10 and P11 may be "carrying their physical forms with them as they still need second step TB tests to be performed" (both were hired in November 2010) b. it is unknown why the health screening forms utilized by the facility, or other physical exam forms, were lacking in the files for P1, P2, P3, P5 and P15			
S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include 9 services	S0406	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft	08/31/2011

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	identified in the list of contracts and agreements in the QA&I program. Findings: 1. Review of the QA&I plan failed to identify how services provided by contract or agreement would be monitored through the program. 2. Review of the facility quarterly QA&I reports failed to indicate the 9 services (medical record consulting, radiology, clinical engineering, renal dialysis, laboratory services, one agency nursing service, one specialty bed provider, pharmacy services and a pharmacist consultant). were monitored to objective, discrete and measurable standards. 3. During an interview on 06-03-11 at 1200 hours, employee #A1 confirmed the 9 services were not included in the quarterly QA&I reports.		correctfon. a. The Directfor oft Qualitfy Managementf or designee will auditf all contfractfs and develop perftormance stfandards ftor each contfractfed service where needed 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The Directfor oft Qualitfy Managementf or designee will monitfor contfractfed services according tfo setf stfandards montfhly and perftorm an annual evaluatfon ftrom montfhly datfa 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All concerns or variatfons ftrom setf stfandards will be reportfed tfo tfhe Qualitfy Assurance Commitfee	

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S0560	410 IAC 15-1.5-2(d) (d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on interview and personnel file review, the facility failed to ensure that the Infection Control Officer was qualified by specialized training in Infection Control for the position and lacked a job description for the Infection Control Officer. Findings included: 1. During interview on 6-1-2011 at 1030, A#2 (CEO) stated that A#1 (CCO - Chief Clinical Officer) was the Infection Control Coordinator at the facility. 2. During interview with A#1 on 6-2-2011 at 1300, there was no documentation to indicate that he/she had any special training in Infection Control. A#1 also stated that he/she did not have any special training or experience in Infection Control. 2. During personnel file review on 6-2-2011 at 1500, A#1's file lacked a job description for Infection Control Coordinator.	S0560	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed, include stfeps tfaken and tfhe datfe oft correctfon. a. Intfegra Specialtfy Hospitfal has contfractfed supportf services ftor an Inftectfon Contfrol Oftcer. The job expectfatfons/descriptfon has been agreed upon in tfhe Inftectfon Contfrol Supportf Service Contfractf in accordance witfh tfhe requirementfs in 410 IAC 15-1.5-2(d). The Inftectfon Contfrol Oftcer supportf service agreementf will commence on Septfember1, 2011. 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The Inftectfon Contfrol Commitfee will review all nominatfons ftor an Inftectfon Contfrol Oftcer and approve candidatfes in accordance tfo *IAC 15-1.5-2 Infecttion Conttirol* stfandards 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. The Chieft Clinical Oftcer or designee will oversee tfhe perftormance oft tfhe Inftectfon Contfrol Oftcer.	08/31/2011

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S0602	410 IAC 15-1.5-2(f)(3)(D)(vi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (vi) An isolation system. Based on document review, observation and interview, the facility failed to follow their policy/procedure to maintain an airborne infection isolation room resulting in a exposure risk for patients, staff and visitors at the facility. Findings: 1. Review of the policy/procedure Negative Airflow Room Testing Policy (approved 11-09) indicated the following; a. The negative-pressure airborne precaution room must be tested utilizing the red-ball indicator before the admission of a patient with actual or suspected communicable airborne disease and daily during the patient's hospital stay [and] b. The negative-pressure airborne precaution room must be tested at least	S0602	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. The "Negatfve Pressure Room" policy has been updatfed ftor our currentf hospitfal locatfon and in accordance tfo -*Guideline for Isolattion PrecauttionsPreventting Transmission of Infecttious Agenttis in Healtthcare SettingsHICPA/CDC, 2007; Indiana Code 410 IAC-1.1: Licensure of Hospittials; American Insttittiure of Architiecttiure Guidelines for Design and Consttructtion of Healtthcare Facilitties 2006.* b. All rooms are in compliance witfh tfhe new "Negatfve Pressure Room" policy. c. Nursing Stfaft have been educatfed tfo tfhe new policy 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe	08/31/2011

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	annually by a service certified in environmental monitoring. The certified service will deteermine ventilation air exchange rates, positive-negative pressure relationships and if the recommended air exchange rate meets regulatory guidelines. 2. On 06-01-11 at 1140, documentation of commercial ventilation testing for negative airflow rooms was requested from employee #A1 and none was provided prior to exit. 3. On 06-02-11 at 1535, during a tour of the facility, it was observed that the negative airflow isolation room lacked a visual monitoring system outside the room to continuously monitor the direction of airflow per the American Institute of Architects (2001) Hospital requirements 7.2.C7 "Rooms shall have a permanently installed visual mechanism to constantly monitor the pressure status of the room when occupied by patients with an airborne infectious disease. The mechanism shall continuously monitor the direction of the airflow." 4. During an interview on 06-02-11 at 1535, employee #A3 confirmed no commercial ventilation testing for negative airflow isolation rooms had been performed and tissue paper testing was performed to verify room airflow		ftutfure a. The Chieft Clinical Oftcer or designee will monitfor compliance tfo tfhe “Negatfve Pressure Room” policy montfhly 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All concerns will be ftorwarded tfo tfhe Inftectfon Contfrol Commitfee and Qualitfy Assurance	

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	direction before an isolation patient was admitted to the room.			
S0606	410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on policy and procedure review, personnel file review and staff interview, the infection control committee failed to create an effective infection control plan related to TB (tuberculosis) testing and immunization history for 9 of 9 agency staff (P1 through P9), related to TB testing for 6 of 6 employees (P10 through P15), related to Rubeola for staff member P13 and Hepatitis B for staff member P15 and related to a health screening or documentation of a physical exam for	S0606	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. The Human Resource Coordinatfor has auditfed all persons employed or voluntfeering witfh tfhe hospitfal tfo ensure all healtfh screens witfh TB tfestf have been perftormed Healtfh screens and TB tfestf have been perftormed where appropriatfe The TB tfestf ftorm has been modifted tfo include tfme read tfo ensure tfestf being read witfhin48 tfo72 hours. b. The hospitfal has modifted itfs policy ftor persons employed or voluntfeering tfo require receiptf oft	08/31/2011

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	152025	A. BUILDING 00 B. WING	06/03/2011

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	agency employees #A6, A9, A10, and A11. Findings: 1. at 3:00 PM on 6/2/11, review of the policy "Infection Control Orientation Outline", with number 07.00.00 - 07.05.02 IC Chpt 3 - A at the top of the page, it reads in "I. General Infection Control Principles...B. employee health 1. Work restrictions 2. Reporting of exposures 3. Vaccines..." 2. at 3:00 PM on 6/2/11, review of the policy, "TB Tests for New Hires", policy number HR Policy 202, indicated: a. under "Process/Procedure:", it reads: "...3. All TB Skin Tests will be read after 48 hours and before 72 hours have elapsed from the time they are placed..." 3. beginning at 10:30 AM on 6/2/11, review of personnel files indicated: a. agency RN, P1, recently worked on 4/16/11, but the last documented TB test was 3/8/10 b. agency staff member P3, a RN, was lacking TB documentation c. none of the TB tests present for agency staff had documentation of the time given and the time the test was read, making it impossible to determine if the TB test was read within the 48 to 72 hours as dictated by policy		immunizatfon records (i.e. Rubella, Rubeola, Varicella, or Hepitftfus B). The Human Resource Coordinatfor or designee has auditfed all persons employed or voluntfeering witfh tfhe hospitfal tfo ensure tfhe receiptf oft immunizatfon records. c. The hospitfal has developed a policy tfo address provisions ftor work restfrictfons oft persons working witfhoutf verifted communicable diseases. The Human Resource Coordinatfor will monitfor all persons working witfhoutf verifted communicable diseases and give appropriatfe restfrictfons when necessary. 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The Human Resource Coordinatfor or designee will ensure tfhatf all persons working or voluntfeering witfh tfhe hospitfal completfes tfhe required healtfh screen witfh TB tfestfThe departfmentf supervisor ftor each person will verifty tfhe completfon oft tfhe healtfh screen TB tfestf and tfhe receiptf oft tfhe immunizatfon records (i.e. Rubella, Rubeola, Varicella, or Hepitftfus B) 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All concerns will be ftorwarded tfo tfhe Qualitfy Assurance Commitfee	

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	d. agency staff member P6, a LPN (licensed practical nurse) and employee P13 had documentation of a negative Rubeola titer, but lacked any follow up as to whether a booster was offered or if the administrative staff have this staff person flagged in some way to relieve them of duties in the event of an outbreak e. agency staff members P1 through P9 were lacking any documentation of history of disease, receipt of immunization or titer results for Rubella, Rubeola, Varicella or Hepatitis B (except Rubeola for P6--see d. above) f. employee P15, a RN, lacked any information/documentation related to Hepatitis B status g. all employee files (P10 through P15) were lacking documentation of the time given and the time the test was read, making it impossible to determine if the TB test was read within the 48 to 72 hours as dictated by policy 4. interview with staff member NE at 2:30 PM and 3:45 PM on 6/2/11 indicated: a. a check with the contracted nursing agency indicated they do not check for immunization status of Rubella, Rubeola and Varicella b. there was no follow up to the negative Rubeola titer of staff member P13			

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	c. it is unclear why there is no Hepatitis B documentation for staff member P15 5. interview with staff members NA and NB at 10 AM on 6/3/11 indicated: a. TB tests for agency and facility employees are lacking the time given and the time read, making it impossible to tell if the tests were read within 48 and 72 hours, as per facility policy b. there is no one tracking negative immunization titers for follow up, such as boosters, or tracking those with negative titers to exempt those staff from work in the event of an outbreak--the infection control plan does not address this c. it is not clear, per the infection control policy (listed in 1. above) what "vaccinations" means and what documentation related to immunization status is required to be part of employee files 6. Review of the policy/procedure Tb Tests for New Hires (approved 01-01-09) indicated the following: It is the policy of TLC Management to adhere to 410 IAC 16.2-5-1.4 on Personnel Practices. The administrative code identified applies to Long Term Residential facilities and does not apply to Integra Hospital. 7. The facility failed to provide a policy/procedure indicating the following:			

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	a. documentation acceptable by the facility from the employee to verify immunity to communicable diseases including rubella, rubeola, and varicella b. provisions for work restrictions related to infectious diseases for at risk personnel without verified immunity to communicable diseases (employee #A12) c. provisions for health records of contracted or agency staff including acceptable documentation to verify immunity to rubella, rubeola, and varicella by the facility or the agency for the involved healthcare worker. 8. During an interview on 06-02-11 at 1545 hours, employee #A15 indicated the facility lacked a policy/procedure requiring documentation of immunity to communicable diseases except Tb. 9. Review of 13 personnel health records indicated 4 contracted services personnel lacked a health screening or documentation of a physical exam in their file (employee #A6, A9, A10, and A11). 10. On 06-02-11 at 1620 hours, employee #A1 indicated the facility lacked a policy/procedure for health records of contracted or agency staff including the provision of a post-offer physical exam or health screening by the facility or the			

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	agency for the involved healthcare worker except for Tb testing.			

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S0912	410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.			
	Based on policy and procedure review, patient medical record review, and interview, the facility failed to implement its fall reduction policy, its Braden scale policy, and its restraint/seclusion policy for 8 of 10 patient records reviewed. (pts.	S0912	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. Fall Reductfon – The ftacilitfy has redeveloped tfhe ftacilitfy ftall reductfon policy. Nursing Stfaft will	08/31/2011

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	N1 through N7 and N10) Findings: 1. at 12:55 PM on 6/3/11, review of the policy "Patient Restraint/Seclusion Policy", indicated: a. on page 3 in the "General Provisions" section, it reads: "1. Alternatives to restraints: will be attempted and evaluated prior to implementing restraint...2. Least Restrictive Means:...4. Orders: a. Restraint shall only be ordered by a LIP (licensed independent practitioner) member of the medical staff..." 2. review of two restraint patient medical records (N1 and N8) during the survey process of 6/1/11 to 6/3/11, indicated: a. pt. N1: I. had soft wrist restraints applied 5/17/11, 5/18/11, 5/20/11, 5/22/11, 5/23/11 and 5/26/11 III. was lacking either partial or full completion of the form titled "Document Patient Assessment for initiation and discontinuation of Restraint/Seclusion by completing this form" (back side of the form for every 2 hours monitoring of patient in restraint) on 5/17/11, 5/18/11, 5/20/11, and 5/26/11 b. pt. N8 had: I. documentation of having restraints beginning at 1800 hours on 2/18/11 through 1800 hours on 2/19/11		be inserviced on tfhe policy by Aug 31 , 2011. All patfentfs have been auditfed tfo ensure appropriatfe ftall risk precautfons have been implementfed b. Restfraintf/Seclusion Policy - Stfaft will be reinserviced tfo tfhe Restfraintf/Seclusion Policy by Augustf 30, 2011. c. Braden Scale – Stfaft will be re-inserviced tfo tfhe Braden Scale policy. The Wound Care Nurse was re-educatfed tfo tfhe guidelines oft daily Braden Scale assessmentfs 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. Fall Reductfon – The Charge Nurse or designee will auditf all patfentfs deemed high risk ftor ftalls daily tfo ensure appropriatfe intferventfons are in implementfed b. Restfraintf/Seclusion - The Charge Nurse or designee will auditf all patfentfs witfh a restfraintf daily tfo ensure compliance witfh tfhe Restfraintf/Seclusion policy. c. Braden Scale – The Wound Nurse or designee will auditf all patfentfs weekly tfo ensure daily Braden Scale assessmentfs have been completfed 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All identffted concerns will be ftorwarded tfo Nurse Governance and Qualitfy Assurance Commitfees	

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	II. restraints resumed at 0800 hours on 2/20/11 with no doctor's orders for restraints III. was lacking completion of the form titled "Document Patient Assessment for initiation and discontinuation of Restraint/Seclusion by completing this form" (back side of the form for every 2 hours monitoring of patient in restraint) on both days of restraint (2/18/11 and 2/20/11) 3. interview with staff member ND at 12:45 PM on 6/3/11 indicated: a. no restraint order for pt. N8 for 2/20/11 could be found b. one side of the restraint documentation form includes information related to alternatives for restraints that were attempted and least restrictive means applied, as per policy requirements as stated in 1. above c. restraint form documentation, required by form and policy, was incomplete as stated in 2. above 4. review of the "Fall Reduction Plan" at 3:00 PM on 6/2/11 indicated: a. under "Procedures:", it reads: "1. Upon admission to Acute Care Unit: a. RN will assess the patient for fall-related risk factors utilizing the "Fall Risk" criteria. b. A fall risk rating assignment is made and documented in the patient			

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	record. c. Safety precautions are immediately put into place based upon patient's fall risk rating..." 5. while on tour of the nursing unit in the company of staff members NA, NB, and NC at 10:40 AM on 6/1/11, it was determined by nursing staff that pt. N1 was a fall risk patient, but that: a. the patient's chart was lacking a tag/sticker indicating a risk for falls b. there was no magnet on the door frame (room 8118 - 1) to indicate the patient was at risk for falls c. there was nothing on the patient's side of the room (shared room) that would indicate this patient was at risk for falls 6. a return to room 8118 - 1 at 1:30 PM on 6/3/11 indicated pt. N1 : a. was lacking a fall risk patient bracelet b. was still lacking identification of some sort to the medical record that would alert staff to the patient's designation as a fall risk 7. interview with staff member NA at 1:45 PM on 6/3/11 indicated: a. there are no written, or clear, guidelines for nursing staff related to the fall risk precautions that are to be put into place based upon the levels of risk that patients are assessed at b. the risk policy states in item c. (see 4.			

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	above) that "safety precautions are immediately put into place...", but no safety precautions are listed for staff to implement 8. review of patient medical records through out the survey process of 6/1/11 to 6/3/11 indicated: a. pt. N2 was admitted 4/25/11 and lacked fall risk assessments between 5/3/11 and 5/13/11 and then lacked assessments on 5/14/11 and 5/15/11 b. pt. N3 was admitted on 4/27/11 and lacked fall risk assessments on 5/9/11, 5/12/11 and 5/13/11 c. pt. N4 was admitted 7/20/10 and lacked fall risk assessments on 7/21/10, 7/24/10, 7/31/10, 8/7/10 and 8/8/10 d. pt. N5 was admitted on 4/10/11 and lacked fall risk assessments on 4/16/11 and 4/17/11 e. pt. N6 was admitted on 4/19/11 and lacked fall risk assessments on 4/23/11, 4/24/11, 4/30/11 and 5/5/11 f. pt. N7 was admitted on 2/11/11 and lacked a fall risk assessment on 2/12/11 g. pt. N10 was admitted 4/16/11 and lacked a fall risk assessment on 4/17/11 9. review of the "Policy and Protocol" titled "Braden Scale Policy", at 3:00 PM on 6/2/11 indicated: a. "1. The Braden scale will be performed daily on all patients in RSH			

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	(Renaissance Specialty Hospital) by nursing personnel/wound nurse." 10. review of patient medical records through out the survey process of 6/1/11 to 6/3/11 indicated: a. pt. N3 was admitted 4/27/11 and was discharged 5/20/11, but was lacking a Braden scale assessment from 5/12/11 to 5/20/11 11. interview with staff member ND at 12:45 PM on 6/3/11 indicated fall risk assessments and Braden scale assessments for patients as stated in 8. and 10. above were missing			
S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on policy/procedure review, observation, facility documentation review, and interview, the facility failed to ensure that all medications and food were maintained at the appropriate temperatures and expired supplies were not available for use.	S1118	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. Medicatfon and Food Temperatfures- The medicatfon and ftood reftrigeratfor tfemperatfure logs	08/31/2011

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	Findings included: 1. Facility policy/procedure review on 6-2-11 Pharmacy Services "Drug refrigerator temperatures and cleaning" stated "a daily record of temperatures for all drug refrigerators will be maintained" and what to do if the temperatures are outside of a certain range (< 35.6 degrees or > 46.4 degrees). Facility policy/procedure "Infection Control For The Food Pantry stated "the refrigerator and freezer temperature will be recorded on a daily basis by a designated employee" and what to do if the temperatures do not meet acceptable ranges (refrigerator: < 32 degrees or > 40 degrees, freezer > 0 degrees). 2. During a tour of the facility on 6-2-11, some Daily Temperature Logs were found to be incomplete and some temperatures were found to be out of range. January 2011: Med Room - refrigerator temp was < 35.6 degrees on 31 of 31 days, Med Room (black) - refrigerator temp was < 35.6 degrees on 29 of 31 days, Food Pantry- freezer temp was above 0 degrees on 2 of 31 days, Med Room (white) - refrigerator temp was < 35.6 degrees on 26 of 31 days, freezer temp was above 0 degrees on 1 of 31 days. February 2011: Break Room - temperatures not recorded on 17 of 28 days, refrigerator temp was < 32 degrees on 3 of 28 days, Med Dispense - temperatures not recorded on 9 of 28 days, refrigerator < 35.6 degrees on 21 of 28 days, Med Room (white) - refrigerator temp was < 35.6 degrees on 22 of 28 days, Med Room (black) - refrigerator temp was < 35.6 degrees on 28 of 28 days, freezer temp > 0 degrees		have been updatfed tfo include tfhe appropriatfe tfemperatfure ranges The log also gives guidance as tfo a stfep tfo tfake in tfhe eventf oft a tfemperatfure is outfside tfhe appropriatfe range b. All supplies have been auditfed and expired supplies have been discarded when appropriatfe Nursing stfaft have been reeducatfed tfo verifty tfhe expiratfon datfe oft supplies prior tfo use 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. Medicatfon and Food Temperatfures – The medicatfon and ftood reftrigeratfor tfemperatfure logs will be monitfored weekly by tfhe pharmacistf and tfhe dietfcian respectfully. 3. Who is going tfo be responsible ftor numbers1 & 2 above? a. All concerns will be ftorwarded tfo tfhe Environmentf oft Care Commitfee or Qualitfy Assurance	

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	on 1 of 28 days, Food Pantry- temperatures not recorded on 2 of 28 days, freezer temp > 0 degrees on 1 of 28 days. March 2011: Med Dispense - refrigerator temp was < 35.6 degrees on 29 of 31 days, Med Room (black) - refrigerator temp was < 35.6 degrees on 16 of 31 days, temperatures not recorded on 1 of 31 days, Med Room (white)- refrigerator temp was < 35.6 degrees 29 of 31 days, temperatures not recorded 1 of 31 days, Food Pantry (TMA#5225) - temperatures not recorded on 1 of 31 days, Food Pantry (white) - temperatures not recorded on 1 of 31 days, freezer temp > 0 degrees on 1 of 31 days, Employee Refrigerator- refrigerator temp < 32 degrees on 7 of 31 days, temperatures not recorded on 2 of 31 days. April 2011: Med Room (small)- refrigerator temps < 35.6 degrees on 27 of 30 days, (black)- refrigerator temp < 35.6 degrees on 22 of 30 days, freezer temp > 0 degrees on 1 of 30 days, temperatures not recorded on 1 of 30 days, Med Room (white) - refrigerator temp < 35.6 degrees on 13 of 30 days, temperatures not recorded on 1 of 30 days, (white) - unable to tell whether it was a food or medication refrigerator, Employee Refrigerator- refrigerator temp < 32 degrees on 1 of 30 days, temperatures not recorded on 1 of 30 days. 3. A#1 and A#2 were on the tour and confirmed that Temperature Logs were not completed and temperatures outside the range were not addressed. 4. During a facility tour on 06-02-11 at 1505, the following was observed in a supply area: 150 yellow microtainer lab tubes with an expiration			

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	152025	A. BUILDING 00 B. WING	06/03/2011

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	date of 2-2011 and 30 purple top lab tubes with an expiration date of 6-2011.			
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on facility policy and procedure review, manufacturer's recommendation, observation, and staff interview, the facility failed to ensure that the crash cart seal was checked and the defibrillator was discharged, as per policy and recommendations. Findings: 1. at 2:30 PM on 6/1/11, review of the Zoll M Series Operator's Guide, indicated in section 10 "General Maintenance: a. on page 10-1, under "Periodic Testing", it reads: "...The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient	S1168	1. How are you going tfo correctf tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. All Charge Nurses will be re-inserviced tfo tfhe "Cardiopulmonary Emergency" policy and procedures relatfed tfo tfhe maintfenance oft tfhe code cartf 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. The "Emergency Crash Cartf Check-Oft Listf" will be monitfored daily ftor tfhe next 30 days and weekly tfhereafter by tfhe Chieft Clinical Oftcer or designee . 3. Who is going tfo be responsible ftor numbers 1 & 2 above?	08/31/2011

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	safety..." b. on page 10-2 under "Semi-Automatic Defibrillator Testing", it reads in item 2. "Defibrillator Test", "Press the ANALYZE button. Verify the unit charges to 30 Joules (30J Ready message)..." 2. at 3:00 PM on 6/2/11, review of the policy "Cardiopulmonary Emergency", reads under section VI. "Procedures", "...Maintenance of the ISH (Integra Specialty Hospital) code cart located at the central nurses station will be the joint responsibility of the charge nurse, lead respiratory therapist...The charge nurse will check the cart seal once per day and test the defibrillator once per shift for proper function..." 3. while on tour of the nursing unit, it was observed that the "Emergency Crash Cart Check-off List", located near the nurses' station with the crash cart, was lacking shift checks as follows: a. on 5/19/11 for 7 PM to 7 AM shift, the seal check and seal # were absent b. 5/19 and 5/20/11 were lacking documentation (on the night shift) as to whether (yes/no) the defibrillator test was "OK" c. on 4/12/11 for 7 PM to 7 AM shift, the seal check and seal # were absent d. on 2/21/11 and 4/15/11, for the 7 AM to 7 PM shift, the seal check and seal #		a. All concerns will be ftorwarded tfo tfhe Nurse Governance Commitfee and Qualitfy Assurance Commitfee.	

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	were absent e. on 3/25/11, 4/1/11 and 4/13/11, documentation on the night shift, as to whether (yes/no) the defibrillator test was "OK", was missing 4. interview with staff member NC, while touring the nursing unit at 2:45 PM on 6/2/11, indicated: a. staff are to document the seal check and seal number every shift as per the check list			
S1510	410 IAC 15-1.6-2(b)(2)(A)(B)(C) (b) The emergency service shall have the following: (2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided. Based on patient medical record review	S1510	1. How are you going tfo correctf	08/31/2011

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	and staff interview, the facility failed to create a clear policy related to patient transfer, and failed to provide documentation of continuity of care for 5 of 5 transferred patients. (Pts. N5 through N9) Findings: 1. at 3:00 PM on 6/2/11, review of the policy "Cardiopulmonary Emergency", indicated under section VI. "Procedures", in section 10. (on page 3) "Designated caller copies necessary medical records of the patient creating a transport pack. 11. If the licensed independent practitioner orders for the patient to be transported to the BMH (Ball Memorial Hospital) Emergency Department (ED):...Transport to the BMH ED requires... and the patient's medical record. 12. If the licensed independent practitioner orders for the patient to be transported as a direct admission...Transport to the BMH ICU (intensive care unit) requires...and the patient's medical record." 2. at 9:45 AM and 1:30 PM on 6/1/11 and 11:00 AM on 6/2/11, review of transfer patient medical records indicated: a. pt. N5 was transferred on 4/21/11 to another acute care facility and was lacking documentation of a "transport pack" and how continuity of care was provided to the receiving facility		tfhe deftciency? Ift already correctfed include stfeps tfaken and tfhe datfe oft correctfon. a. A new patfentf tfransfter policy has been developed including a patfentf tfransfter checklist tf nurses and physicians have been educatfed tfo tfhe new policy 2. How are you going tfo preventf tfhe deftciency ftrom recurring in tfhe ftutfure? a. All patfentf tfransfters will be auditfed by tfhe Chieft Clinical Oftcer or designee ftor tfhe nex 30 days. Ift 100% compliance is achieved, tfhen a random sample oft no less tfhan 10% oft all patfentf tfransfters will be monitfored tfhereafter 3. Who is going tfo be responsible ftor numbers 1 & 2 above? a. All concerns will be reviewed by tfhe Utflizatfon Review Commitfee and tfhe Qualitfy Assurance Commitfee.	

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	b. pt. N6 was transferred to a physician's office (for an appointment) and did not return to the facility--was admitted to another acute care facility---but lacked any documentation related to the transfer of medical information to the receiving facility for continuity of care c. pt. N7 was transferred to the ED on 2/14/11 and was lacking documentation of a "transport pack" and how continuity of care was provided to the ED d. pts. N8 and N9 were transferred to the host hospital's ICU and were lacking documentation of a "transport pack" and how continuity of care was provided to the ICU 3. interview with staff member ND at 1:15 PM on 6/2/11 indicated: a. the facility does not utilize transfer forms b. there is no specific policy related to the process of transferring patients, this information is imbedded in the "Cardiopulmonary Emergency" policy c. it is not clear, in patient medical records for pts. N5 through N9, how continuity of care and medical information was transferred to the receiving entities d. it is unclear what the "transport pack", mentioned in the policy cited in 1. above, includes			

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